UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES OF AMERICA, et al.,	)	
	)	Civil No. 18-2340
Plaintiffs,	)	
v.	)	
	)	Washington, D.C.
CVS HEALTH CORPORATION, et al.,	)	June 5, 2019
	)	Day 2
Defendants.	)	Afternoon Session

TRANSCRIPT OF MOTIONS HEARING
BEFORE THE HONORABLE RICHARD J. LEON
UNITED STATES DISTRICT JUDGE

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(Appearances continued on next page)

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E X A M I N A T I O N S

AFTERNOON SESSION

(2:58 p.m.)

THE COURT: Are you ready to call your next witness?

MR. PITT: Yes, Your Honor.

We call Dr. Alan Lotvin.

THE COURT: All right.

ALAN LOTVIN,

having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PITT:

Q. Good afternoon, Dr. Lotvin.

Could you please state your full name for the record.

A. Alan Lotvin.

Q. And what position do you hold with CVS Health?

A. I am the Executive Vice President and Chief Transformation Officer.

Q. What does that job entail?

A. So my role really is to take the assets capabilities and talents of both organizations and combine them in ways to increase access to high quality, low cost care, and reduce overall healthcare costs in the system.

Q. Is that a job that existed prior to the time when CVS and Aetna were considering a merger?

A. It did not.

Q. Do you have experience in other areas of healthcare?
A. Yes. I was a practicing intervention cardiologist for several years in the New York City area. I spent roughly 20 years in the pharmacy benefit management industry, specifically within specialty pharmacy. About a year, year and a half in medical education, and a couple of small start-ups in between.
Q. Now, when you were a practicing cardiologist, were you a member of the American Medical Association?
A. I was.
Q. And were you also on faculty?
A. I was. I was on the faculty at The College of Physicians and Surgeons at Columbia University.
Q. Could you briefly provide the Court with your educational background.
A. Sure. I have a Bachelor's in Science and Biochemistry from The State University of New York at Stony Brook, and a Doctor of Medicine Degree from the State University of New York Downstate Medical Center, and a Master's in Medical Informatics from Columbia University.
Q. What is medical informatics?
A. Medical informatics is the application of data science and information science in all of its myriad manifestations to the medical domain.
Q. Could you just give the Court an overview from your

perspective of the different players in the healthcare industry.

A. Sure. I will work from the patient kind of out. So if you start with the patient, the first level of people who would plan the system would be providers; so physicians, pharmacists, hospitals, nurses, nurse practitioners. You go one step beyond the providers and would get to sort of the organizations that connect all the dots, so pharmacy benefit managers and health insurers, who connect the providers with the ultimate payers, which in our system is either the government or the employers, in general.

Q. So you've mentioned PBMs or pharmacy benefit managers a couple of times. We've, obviously, heard a lot about that over the last couple of days. But can you give the Court from your perspective an understanding of what is a PBM.

A. So just at its most basic, the PBMs provide four main services:

So, one, think about it as procurement of drugs. How do I get the best price from the pharmaceutical manufacturer, whether they're branded manufacturers or generic manufacturers?

The second would be to construct pharmacy networks on behalf of our customers. Again, as was discussed many times, helping them understand that trade-off between ease of access and convenience and price.

The third would be clinical programs. So pharmacy benefit managers employ programs for adherence to help people stay on their meds. They do things like drug utilization review and, for certain lines of business, comprehensive medication reviews for people on multiple drugs, so there is a safety and quality perspective part.

And then, there's, for want of a better term, the plumbing. Making sure that when someone shows up in the pharmacy, everyone in the system understands precisely what the eligibility of that patient is, what the plan design is, how much the out-of-pocket for the member is going to be. So it really enables complete transparency and prevents the surprises that you see in many other areas of medicine where people go and get a service done and have no idea what it is going to cost until they get the bill.

Q. Now, yesterday's witnesses testified that PBMs control decisions like which pharmacies are in network, which are preferred, what the co-pays are.

Based on your experience in the PBM business, is that a correct statement of who makes those decisions?

A. No. It's absolutely a hundred percent the opposite. The pharmacy benefit manager basically acts on behalf of the plan sponsor, whether it is a government payer, a private payer in the employer business, or a fully insured health plan. And they have their own goals, needs, desires about

how they want to go to market. And they'll construct plan designs that are in accordance with their beliefs and their desires.

So we administer literally tens of thousands of combinations of plan designs and formulary constructions and network constructions in order to meet the needs of those plan sponsors, which creates a tremendous amount of administrative complexity just from the simple IT perspective. It really takes a lot of work to meet the customization needs of all of those different customers.

Q. So, in this kind of health ecosystem, where do you see CVS fitting in?

A. So CVS kind of plays throughout that infrastructure. One, we're a provider of care. Our pharmacists provide care to patients every single day. Our nurse practitioners also provide care in the MinuteClinics. And then we also have a group of home infusion nurses, who literally go into the home and provide therapies that need to be administered intravenously, often for people with highly complex diseases or who just came out of the hospitals. So we're providers.

Under both the CVS Caremark umbrella, we provide the administrative services, that plumbing we talked about a second ago. And also Aetna does the same sort of function on the medical benefits side, so we are the intermediaries.

As a fully insured, meaning when Aetna owns the

medical risks, they're the payer for government programs like MA, they're the payer. Lastly, we have 300,000 employees, so we have a lot of patients, too.

Q. You mentioned a few things that I would like to hear a little bit more about, if I could.

First, you have described pharmacists as being care providers among other things. In what way are pharmacists care providers?

A. So, in several ways. In their traditional role in pharmacy, there's a safety role, ensuring that people know how to take their drugs, take the drugs safely, are not on drug regimens that are contradictory or duplicative. They also provide counseling around important things like adherence and staying on your medications and overcoming barriers that exist to that. Those can be all sorts of different barriers.

In many places, pharmacists -- the scope of practice for pharmacists is expanding. So they can provide immunizations. In certain states, they can have a limited prescriptive authority. And what we're seeing more and more are things called collaborative practice agreements, where pharmacists can work under the aegis of physicians to make very specified decisions, so they can titrate blood pressure medications against the target, they can titrate lipid-lowering drugs against the target.

Q. You also mentioned MinuteClinics, another topic that we've heard a bit about. From your perspective, what are the MinuteClinics, what role do they play?

A. Great questions. The MinuteClinic started out, was exactly the phrase, MinuteClinic. Their motto used to be "You're sick, we're quick." And it was all about kind of cough, cold, flu, just off hours. We called it low-acuity acute care.

What we found as we have worked in that environment, about 50 percent of people who we see in the MinuteClinics don't have a primary care doctor. So we refer millions of people a year to primary care doctors.

What we also serve is a real need to create greater access. Everybody knows about the physician shortage. So over the past several years, culminating with some work we recently announced in Houston, we have expanded the scope of practice for MinuteClinic to cover roughly 80 percent of the scope of practice that you would see in the typical primary care office. They're staffed by nurse practitioners and physician's assistants under the supervision of physicians. So it is much like physicians offices use nurse practitioners, we're using nurse practitioners to create more access, more convenience, I think more certainty. People know exactly how long the wait time is. They know exactly how long the visit is going to be. They know exactly what it

is going to cost. So that combination of convenient access, transparency of experience, and high-quality care has really been kind of a real disruptive force in the industry.

Q. You also mentioned -- and we know from other witnesses -- that CVS participates in the PBM market. And is that through CVS Caremark?

A. That's correct.

Q. This may seem like an obvious question, but is it part of CVS's strategic plan to grow its PBM business?

A. Absolutely.

Q. And how do you plan to do that?

A. The PBM business, it's an intensive competitive business. And if you go and talk to the consultants, they would tell you that the criteria for winning PBM business is price first. And if they're being tongue in cheek, they'll say first, second, and third. Then service. And assuming you meet those two standards, then the real question of differentiation and unique services and unique products comes to fore. But first and foremost, you have to hit the price standard. And by price standard, specifically unit price.

Q. Now, do CVS's plans for its PBM business include doing business with insurance plans that compete with Aetna?

A. Yes. A very important part, as you heard this morning, of the business.

Q. So can you explain in your own terms why does it make

sense for CVS Caremark, the PBM, to work with Aetna's competitors given that now both the PBM CVS Caremark and Aetna are part of the CVS corporate family?

A. So, across the entire organization, the mandate for us is to grow the business. And the way you've always grown the business in the PBM industry is by winning new clients. The only way that we're going to win new clients is continuing to provide extraordinarily high levels of service, meet and exceed price expectations -- and "exceed" means better discounts -- and then bring to market unique capabilities. So, as we think about the post-merger world, we have the opportunity to very clearly work with every health plan that currently works with us and others to differentiate the Caremark services from our competitors in the PBM space.

Q. So can we look at the flip side of that. I would like to ask why is it that insurance companies that compete with Aetna or SilverScript would choose to work with CVS Caremark as their PBM?

A. So let me use SilverScript as an example because it is actually a really good one. So SilverScript is CVS's own Part D plan. As part of our strategy -- this is pre-merger -- part of our strategy was to grow out business with other health plans who also provided Part D plans. And we would go out and we would help them in several areas.

One, the Part D program is a heavily regulated, compliance-dependent program. We were really good at that. Two, we were really good at the general service part that we talked about with the PBM. We had great prices. And three, we helped them drive up their star scores, which as a quality metric is incredibly important.

What we found is that the Part D plans who used Caremark or CVS Caremark as a PBM grew faster than the market. So we were able to enable their growth while we were still growing the SilverScript business. So both lanes, both channels of competition were growing very rapidly. In fact, the plans who used us grew faster than the market. They met their business needs as well.

That is the sort of the analogy we're using with the Aetna book of business. We want to bring new products --

THE COURT: Hold on.

The Aetna book of business, that is PDP business.

THE WITNESS: I was going to switch from PDP to specially the Aetna health plan business.

So we did the same thing with that. Aetna was a PDP customer of ours, as well --

THE COURT: Right.

THE WITNESS: -- pre-merger.

THE COURT: But the way you had a competitor for their Aetna PDP business was with SilverScript; right?

THE WITNESS: SilverScript and several other health plans used us as a -- several other health plans with PDP plans used Caremark as their PBM.

THE COURT: Let's not merge all that right now.

THE WITNESS: Okay.

THE COURT: You had your own business, SilverScript --

THE WITNESS: Yes.

THE COURT: -- that was competing directly with Aetna's PDP plan; right?

THE WITNESS: That's correct.

THE COURT: What business did you have of your own that was competing with Aetna in non-PDP health insurance? Any?

THE WITNESS: No.

THE COURT: No.

You don't compete with them in that arena?

THE WITNESS: That's correct.

THE COURT: So I'm concerned about how this all gets merged together here. The question that he just asked a minute ago blurs it altogether.

You're not competing, and haven't been competing, with Aetna except in the PDP arena with SilverScript.

THE WITNESS: That's right.

THE COURT: Let's keep that clear.

MR. PITT: Certainly.

THE COURT: You're merging it too much.

MR. PITT: Certainly.

THE WITNESS: So, then, I will answer the second part of the question, which was why would Aetna want another part of CVS to work with Aetna's health insurance competitors. So separate from the PDP. Is that an okay question?

THE COURT: Who do you have in mind for health insurance competitors? Give me an example.

THE WITNESS: WellCare would be an example.

THE COURT: WellCare at the moment is --

THE WITNESS: Molina, Centene, the Capitol District Health Plan in New York, NVP, all the Blue Cross/Blue Shield plans, Blue Cross/Blue Shield of Idaho, all of which would be competitors of Aetna as health insurers.

THE COURT: You're continuing to offer them PBM services --

THE WITNESS: Correct.

And we want to offer more of them more PBM services. That's a core part of our growth strategy. In fact, several years ago we were very public that our core strategies for growth in the PBM were Part D, health plans, and specialty pharmacy.

THE COURT: What is the last one again?

THE WITNESS: Specialty pharmacy, drugs that are

10,000 to a million dollars a year for people with generally uncommon chronic conditions like multiple sclerosis, hemophilia, etc.

THE COURT: Okay. Thank you.

BY MR. PITT:

Q. Why don't we move on to discuss some of what you see as the benefits of the merger.

First, just to kind of get ourselves oriented, could you describe your role in the implementation of the merger.

A. Yeah. So I took my role about six months or so prior to close. And at that point we had already done a fairly deep dive into the core -- the near term synergies, which really fell into three big buckets, of which one was medical cost savings. And so we had a very specific set of programs that we were going to and have initiated to help lower healthcare costs.

What my group's role was, in the six months prior to close, was to say, okay, we know what those are going to be. So how do we look forward and say, over the longer term, how do we create meaningful incremental value through the combination of the different assets of these two companies. Part of that was extending those ideas and making them bigger. And some of it was creating new programs, new ideas that would not have existed had we not put these two organizations together.

Q. Maybe a different way to look at it is, from your perspective, was there a particular problem that CVS and Aetna were looking to solve with this merger; and if so, how did they do that?

A. Yeah. So the big picture, right, the big picture that we're trying to solve is chronic disease. So if you look at the healthcare industry in this country right now, we're really pretty good at acute episodic illnesses. You have a heart attack, you get in a car accident, you break a leg, we have really good outcomes. And some of it is at too high of a cost, but we have really good outcomes.

If you look at chronic diseases, it is where all of the burden of illnesses, 60 percent of adults in this country have a chronic disease. Chronic disease is responsible for between 70 and 75 percent of the entire spend in the country.

And the difference between an acute problem, it is self-delimited by definition; whereas, a chronic disease really requires changing an individual's behavior over the long-term in order to either avoid the full development of disease in something like prediabetes or to avoid the progression of the disease and the resulting morbidity, mortality, and costs.

And our belief very strongly is that in order to really change people's behavior, you need to be part of their life, you need to be there to help them and support them in

making those everyday decisions that change the trajectory of chronic disease. Am I going to park at the far end of the parking lot or the close end? Am I going to follow up with my doctor or not? Am I going to get the lab test or not? Those sorts of things. There's no magic bullets for high blood pressure. There's no magic bullets for diabetes.

So what we want to do is bring more services closer to people in their communities that make it more convenient, lower cost, to be able to get those services, experience them, and understand how to change their behavior so they become active participants in their own care, ultimately reducing the morbidity, mortality, the bad outcomes, which in turn reduces cost. Right?

Someone with diabetes who controls it doesn't end up in the hospital every year. Not just they're healthier -- which is really the important part -- they also don't cost any money. It doesn't cost them any money. Right? They don't have to spend their out-of-pocket deductible, the co-pay, and it doesn't cost the payer any money.

So that is sort of the secret sauce of what we're trying to accomplish and why we put these two companies together.

Q. Okay. So how is it then that the combination of these two companies makes it possible to address that problem? Or what does the one have that the other needs and

vice versa?

A. So what we thought, what we saw was the opportunity to take an organization like Aetna, which had complete access to all of the medical claims data, as well as medical and pharmacy, what we thought was a really world-class analytic organization, a very robust physician and provider network, and marry that up to an organization, CVS, that already is part of people's lives. So we make 300,000 home visits a year. We have 4 and a half million people a day who walk into our stores. We're within 3 miles of 70 percent of the U.S. population. And as we look to a more digital, technologically advanced world, we have affirmative permission to text a lot of people.

And so those touch points, the ability to talk to people the way they want to be talked to is the way that we believe we'll be able to change behavior. So we do the analytics. We look at all the data. We decide what the next best action for an individual is. And then we deliver through whichever one of those channels that person wants to be communicated with.

Q. Now, is there also a financial incentive component to why it is that the putting together of these two organizations enables you to achieve the goals that you were just talking about?

A. So what I would say is this is not a new thought,

right? We have been trying to do this for a while in a lot of different fashions. And what we found is, when you're trying to create a commercial relationship with a payer that says, hey, give me all your data, let's do the analytics together, let's decide the next best thing to do for your customers and we'll deliver it in the stores, we found that the amount of investment we would have to make or we have to make was almost unsustainable if you didn't enjoy the fruits of that by reducing medical cost and being on the hook for medical costs. You always got into an argument over whose services actually resulted in the better outcome, and could never reach a commercially reasonable arrangement to justify the investment. And even if you could, the other challenge was, as was noted earlier today, the average contract is 3 years.

So it is kind of hard to make -- we announced yesterday that we were going to build 1,500 of these HealthHUBs around the country.

THE COURT: Is that different from the MinuteClinic?

THE WITNESS: Yes, it is very different.

THE COURT: How is it different?

THE WITNESS: So HealthHUBs -- what we have done in the HealthHUBs is four things. One, we've taken out about 15 percent of the selling space and devoted it to health and wellness. We've expanded the size of the MinuteClinic.

Instead of having -- the average MinuteClinic has two rooms; these have four. We have added staffing in the MinuteClinics to be able to handle a bigger flow-through of patients. We have expanded the scope of services within those clinics to include blood drawing, cameras to take pictures of the back of people's eyes who have diabetes, things like sleep apnea screenings, which is hard to do.

We have also expanded what the pharmacists are doing. So we basically gave the pharmacist a list of what you would call the 180 sickest people around the store and say, listen, we really want you to get in touch with these people. And there's a very specific message for each person, that, quote/unquote, next best action. And what we have seen is that they're very, very effective at that. People actually engage with their pharmacist on a routine basis.

The last thing we did is we build what we call a wellness room. It is a room that -- it's two rooms -- that can be used for dietitian services, can we put a dietitian in the store. It can be used for social work services. And we make it available to the community. The American Heart Association has had events in our stores in Houston. We have done chair yoga. And it is just to get people out of their house dealing with some of the social determinants of health.

So we're very pleased and very excited about the early results from the three we built in Houston, and we

committed to building 1,500 over the next two years by the end of 2021.

So that is a level of investment that we wouldn't have been able to make if we hadn't had the assurance that we will be able to lower healthcare costs over the long-term.

Q. Since you're on the topic of HealthHUBs and what I think you've referred to as pharmacy panels, the notifying of pharmacists to contact high-risk patients, do you have any examples of how expanding MinuteClinics services have benefited customers?

A. Yes. There's a couple of things I can share with you. So one is -- and we talked about this yesterday -- the score which is a measure of satisfaction that crosses industries, these stores are up 900 basis points, so 9 full percentage points, and that's off a high number of 66, so it's all the way up to 75. The overall satisfaction with both the pharmacy and MinuteClinic in these stores is also significantly elevated compared to the rest of the chain.

And we have a couple of, admittedly, anecdotes. We have only been open for 4 months. At least one example I can share quickly. A gentleman came into the MinuteClinic complaining of belly pain, what we see all the time. The nurse practitioners were able to diagnose that he had uncontrolled diabetes, some other medical conditions, hadn't seen a primary care doctor in 3 years. They did an

evaluation of the back of his eyes, the retina, found that he had significant changes that would predispose him to blindness and got him into the system, got him referred into a primary care doctor just from belly pain.

Another woman came in and was literally shopping in the protein powder aisle, and one of the employees sort of asked her if she needed help. She mentioned that she was trying to lose some weight. He asked her if she wanted to see the dietitian. Walked her over to the dietitian. They had a 5- or 10-minute discussion because she also mentioned to the dietitian that she felt awful, that she had a throbbing headache. Got her blood pressure taken. It was 200/120, which is significantly elevated. Brought her right over to the MinuteClinic. Again, same sort of scenario. Hadn't been seen by a doctor in years. Knew she had high blood pressure but wasn't treated. The nurse practitioners diagnosed it, started her on appropriate therapy. They followed up with her several times weekly, and learned that the woman had several members of her family who had strokes.

These are anecdotes, but it really speaks to the fact that connecting all these dots for people, putting more services that are closer to them in their community makes a difference in the long-term outcomes. Like I said, they're anecdotes, but if you add up enough anecdotes -- which we will -- and it turns into data.

Q. So with an anecdote like that, is that something that could have happened before the merger? What does it have to do with the merger?

A. So it's a couple of things. So those two -- one is -- we expanded these MinuteClinics in Houston based on an evaluation of the Aetna data, which said there was a high concentration of people with chronic disease around these specific stores. We knew from the demographic data that there was a paucity of primary care physicians in the area. So we would never have expanded services to that extent without that data, certainly wouldn't have put a retinal camera in. They're very expensive. So it is an example of how the combination of the data and our belief in our ability to impact it allowed us to make an investment in advance of sort of proof.

Q. Let's talk about another one of the initiatives that the merger has spawned, the hospital readmission prevention program. Can you explain to the Court what that is, how it has worked.

A. Sure. So about 50 percent of hospital readmissions are due to medication errors or problems. And you can imagine, right, someone goes into a hospital with a bag of medicine A, they come out of the hospital with bag of medicine B, different doctors. A and B don't match. They're duplicative. They're contradictory.

And so we had a program that we actually ran as a pilot about three or four years ago -- we published this in a peer-reviewed medical journal -- that demonstrated a comprehensive medical review, meaning the pharmacist going through the entire medical history with the patient, could reduce readmissions substantially. We published it in a medical journal. We actually did that pilot with Aetna.

We were never able to turn that into a commercially viable program for the reasons I talked about earlier. We couldn't agree on whose intervention made the most sense, etc.

Now as one company, not only are we expanding that -- not only are we executing on that program now as part of our near-term medical costs, but we're also saying, okay, now as one company, I know, because of the work that the medical management team does within Aetna about who's in the hospital, how long in the hospital, we know when people are going to be discharged. So now we can connect that discharge event to a much more timely medication reconciliation.

So if I can do that review of the medication regimen as soon as possible after the person is discharged, preferably before they even start taking bag B of drugs, we can avoid a substantial number of hospital readmissions. And every one of those is between twelve and a half and twenty-five thousand dollars. So good for patients, good for

the payer. And because we own the entire chain and the risk of that $25,000, making the technological investment to understand exactly when they are discharged, flagging those patients who are already CVS patients, so that when they show up in the store the pharmacist knows, wait a second, this person just got out of the hospital, something that doesn't exist today, but we're going to build it.

THE COURT: One of the advantages of the merger that you foresaw, was it not, was that your PBM business would be strengthened?

THE WITNESS: We already had Aetna as a PBM. So I don't know that it necessarily would be strengthened. I would almost say --

THE COURT: Well, wait a minute.

Are you telling me that you didn't think it would be a stronger negotiator with manufacturing companies and wholesalers if they had the 19 million customers from Aetna? Are you being straight with me? Come on.

THE WITNESS: I am.

THE COURT: You didn't think it would improve their bargaining ability?

THE WITNESS: Remember, we already had --

THE COURT: Answer that question.

Did you think it would improve their bargaining ability to get lower-priced drugs?

THE WITNESS: It would not incrementally improve it because we had those lives under management already. And we have a contract --

THE COURT: You had them under contract that could come to an end within a year or two. There is a big difference between that and being under your umbrella now that you own them. You own those 19 million relationships now outright.

THE WITNESS: With all due respect, those relationships that Aetna has, those also are time-limited contractual relationships with employers and payers. So the 19 million lives that Aetna has are -- many of them are -- they work the same way as the PBM relationships. They can leave next month or next year.

THE COURT: Next month?

THE WITNESS: Next year.

On a rolling annual January 1st cycle, those contracts come up for renewal. And Aetna has to have a competitive PBM offering, a competitive medical network in order to retain their business.

THE COURT: Have you seen in the 6 months since this merger -- it is more than 6 months, actually -- since this merger went through that your PBM business is stronger and negotiating lower prices for consumer drug purchases with wholesalers and manufacturers?

THE WITNESS: So, I'm no longer part of the PBM. I'm no longer in the manufacturing area. But what I can tell you --

THE COURT: How long have you not been working with the PBM part of the company?

THE WITNESS: A year.

THE COURT: A year.

So you don't have any knowledge as to whether the PBM part of the business has been strengthened in their negotiating ability as a result of this merger to date? You don't know the answer to that question?

THE WITNESS: I don't know the answer to that question.

THE COURT: Who does?

THE WITNESS: Gary Loeber.

THE COURT: What's the name?

THE WITNESS: Gary Loeber.

THE COURT: How do you spell that last name?

THE WITNESS: L-O-E-B-E-R.

THE COURT: What is his title?

THE WITNESS: Executive Vice President for Trade Relations.

THE COURT: Will you get me the answer to that question, please?

THE WITNESS: I can get you the answer to that

question.

THE COURT: Send me a letter with the answer to that question.

THE WITNESS: I will.

THE COURT: Thank you.

BY MR. PITT:

Q. All right. Let's talk about improving chronic care management.

THE COURT: Hold on. I want to finish up on something else on the PBM.

MR. PITT: Of course.

THE COURT: You said earlier today that the insurer, the company that purchases the services of the PBM business that you all have is the one who will dictate -- I don't know if you used the verb "dictate" -- but who will set the terms, for lack of a better word -- I don't have a transcript in front of me -- of what drugs they want covered, what prices they want for those drugs, and what network availability size they want to have.

Is that what you said?

THE WITNESS: First and third. So they will dictate -- so many -- the way formularies work, many health plans will have their own custom formulary.

THE COURT: Okay.

THE WITNESS: So we have several standard formularies

within CVS Caremark.

THE COURT: Uh-huh.

THE WITNESS: Most of our employer customers will use one of those standard formularies.

THE COURT: Okay.

THE WITNESS: There's two or three of them. But most health plans will have a custom formulary, meaning they will either take our standard formulary and decide on a drug-by-drug basis, want that, don't want that, love that, hate that. Or they'll say: You know what? We want you to replicate our current formulary because we have our own pharmacy and therapeutics committee. This is what we want. You're going to bid for our business based on your ability to negotiate for these specific drugs.

THE COURT: Okay. So one of the ways that your PBM services business competes against other PBM services is their ability to design, customize formularies that will meet the needs of the prospective insurers?

THE WITNESS: That's correct.

THE COURT: Okay. So that is one way.

Another way is to offer, I assume -- correct me if I'm wrong -- highly competitive, if not superior, prices?

THE WITNESS: Right. So you're evaluated essentially on a spreadsheet that says what's your price for generic drugs, what's your price for brand drugs, what's your price

for specialty pharmaceutical drugs, what are your administrative costs, what are your fees for other things. It is a very standardized --

THE COURT: So when the PBM puts in the bid, so to speak, it puts in the prices that it believes it can get for those drugs; correct?

THE WITNESS: Yes. Obviously, that is proprietary information, so we will often do it in aggregate.

THE COURT: Right. But it is a blind, too. You don't know what the other PBMs are offering; do you?

THE WITNESS: That's correct.

THE COURT: That's correct.

And you're doing it based upon your negotiations with the wholesalers and the manufacturers?

THE WITNESS: Yes.

THE COURT: And so it's a function of what you believe is the best price you can offer the insurer as to the specific drugs on their formularies?

THE WITNESS: That's right.

THE COURT: So as to the pricing, the insurer doesn't have any guidance ability to set what those prices are going to be. They're relying upon the competitor -- the competition -- excuse me -- of the companies -- maybe it is two companies, maybe it is five, whatever -- they're relying upon the competition generating the best deal, so to speak,

for their customers.

THE WITNESS: That's true. Many of the insurers will also have their own contracting staff. And they will go out sometimes and negotiate directly with manufacturers and hold those rights for themselves in their contract. So they'll say, well, we'll use your formulary unless we can get a better price on our own.

THE COURT: They do that before or after they set up a contract with the winning PBM?

THE WITNESS: What they will usually do -- so they're going to make a decision on pricing based on a combination of -- I will make it simple. They will essentially look at what their current utilization is. They'll say, okay, if I take my current utilization of drugs and I lay out your proposed rates, guarantees, rebates, etc., will that cost me Y? And if I look at PBM 2, that costs me Z. And they will decide, well, if Y is much greater than Z, I'm going to go with Z, unless of course they have had a bad experience with Z in the past in terms of service, whatever.

THE COURT: Right.

THE WITNESS: In general, they're going to go with the lowest-priced PBM.

But then as part of the contractual negotiations many of the health plans will look to retain certain services, both as a way of maintaining control -- so I think earlier

today you showed the example of the WellCare versus Anthem contracts -- versus Aetna contracts broken out. You saw that there was pharmacy network contracting. They will sometimes hold back certain things that they believe they either might be able to do or might want to do in the future. So that is one way of adding additional sort of pressure on whichever PBM they choose.

Another way that they add pressure on whatever PBM they choose is they will ask for what are called market checks or demand market checks, which means, even if you have a 3-year contract, many times every year or twice during the contract or once during the contract, that PBM client will have the right to take the business back out for a market check. And the reason they want to do market checks is because historically prices have done nothing but decrease in the PBM industry. So what they don't want to do is get out of market, get to a point where they don't have the best price in the market.

So it puts a tremendous amount of competitive pressure on the PBMs to always be improving their negotiated discounts with both manufacturers and with retail pharmacies because that is how they are evaluated.

THE COURT: With regard to the PBMs who cover the PDP business, you said earlier that the PBM services part of the CVS business would not act in a way that would be detrimental

to the WellCare Aetna folks --

THE WITNESS: That's right.

THE COURT: -- so as to advantage SilverScript.

THE WITNESS: That's correct.

THE COURT: And one of the ways you can ensure that that won't happen is that there's a firewall of information.

There is a firewall, is there not?

THE WITNESS: There is absolutely a firewall.

THE COURT: So they're not in a position to know certain information that might put them in a position to advantage, let's say --

THE WITNESS: That's correct.

THE COURT: -- the SilverScript business and disadvantage the Aetna -- the --

THE WITNESS: That's correct.

THE COURT: Okay. So how about with regard to non-PDP business; are there firewalls in place of any kind such that the PBM folks will not be incentivized or even capable of disadvantaging competitors by restricting access to the CVS pharmacies, of which there's 7,900?

THE WITNESS: I will answer the -- the firewalls are absolute. The firewalls exist between the pharmacy, CVS pharmacy, and CVS Caremark and between CVS Caremark and CVS pharmacy and Aetna. So anyone in the CVS pharmacy business has no idea how Caremark, or CVS Caremark, is contracting

with Walgreens or Wal-Mart or Albertsons. No idea whatsoever.

THE COURT: Separate profit centers.

THE WITNESS: They're reported separately. They're measured separately. The access just doesn't exist.

In Caremark, the Caremark folks have no idea what rates the CVS pharmacy people are giving to Express Scripts and Optum and Prime and MedImpact and the whole realm of the 40 PBMs that exist.

So, similarly, the Aetna team has no idea -- they don't know what any rates that Caremark is giving to any other health plan. There isn't another analogy because Aetna is only working with --

THE COURT: Right.

THE WITNESS: -- so there is an absolute firewall. And in terms of incentives, our entire management incentive plan is based on the enterprise performance. So what we are all incented to do is grow the entire enterprise. And to grow the entire enterprise, Aetna has to be able to work with as many employers as possible. CVS Caremark has to work with as many health plans and employers as possible. And CVS retail has to be able to work with as many PBMs and insurers as they can. Because as you point out, Aetna is 22 million lives, Caremark is 90 million, and at CVS pharmacy we probably see a third of the people in the country over the

course of the year. We simply couldn't run our business on the 22 million Aetna lives. It would be economic suicide to do something different.

THE COURT: Okay.

BY MR. PITT:

Q. So I guess getting back for a quick moment to the benefits of the merger. Will those benefits, that is, the new programs you've talked a little bit about and hopefully the better health outcomes and the savings, will those benefits accrue only to Aetna's customers?

A. No. So, first, they will accrue to any customer who uses the programs. So any one of our PBM customers or retail pharmacy contract partners who avail themselves of the program will see the same savings.

In addition, the individuals who don't have an event or who don't end up in the hospital, they will not only enjoy better health, which is probably their main goal, but they also won't have to pay a co-pay, they won't have to pay their coinsurance, they won't have a deductible. Ultimately, as we reduce overall costs, premiums come down. And for the insured, premiums come out of people's pockets indirectly. So I think that there is both an organized kind of payer benefit, there is a patient benefit, and then there's kind of health benefit.

Q. And can you describe how sort of proof of concept

might work in connection with spreading the benefits to PBM customers who are not Aetna insureds?

A. Yeah. So the first program that we brought into market since we've been a combined program has been a chronic kidney disease program. It is just a huge unmet need. It is a big problem for all payers. And before we launched it with Aetna, we had been out talking to a number of the large CVS Caremark health plan clients. And I would say there is a lot of interest in both that program, as well as the next program we're bringing to market over the summer in oncology. And so we're trying to work with them to understand how that's going to work, how do we get the data.

And then we announced we're going to put 1,500 hubs in. Before we had announced that, I had personally talked to two health plans, and they were very interested. And they said: Look, we know you are only doing this as a pilot. We know they're only three up. But we really want to be the next market, like we see this as a big opportunity.

So I'm sure that -- I'm sure -- I know for a fact that the teams who take care of those customers reached out to them yesterday afternoon after we made the public announcement about 1,500 hubs, to start understanding that process, because it requires data, it requires contracting, it requires paying for services. So we're going to get started on that. As we build those out, that will help

inform our roll-out strategy for where we put these 1,500 over what time frame.

Q. Getting back to MinuteClinics, as well, we've heard some testimony about concerns that perhaps part of the plan might be to steer Aetna insureds to MinuteClinics. Is that something that the company is planning to do?

A. So our only goal in expanding use of MinuteClinic -- at least our goals in expanding use of MinuteClinic I would broaden to say, first, we want to reduce ER utilization.

There are three ways of reducing ER utilization. One is you make sure people get into the primary care system so that they get treated and they don't develop problems. Two, you build awareness of alternative sites of care other than emergency rooms. And those would include MinuteClinics, everyone else's retail clinic, and urgent care centers. Quite frankly, the win here is not sending someone to MinuteClinic and earning a little bit of margin on the nurse practitioner's service, the win is avoiding that $3,000 hospital ER visit that didn't have to happen.

THE COURT: How much is a MinuteClinic visit?

THE WITNESS: They range between $39 and $119.

THE COURT: You take credit cards?

THE WITNESS: We take credit cards. We take cash. If you have multiple services, you can get into a

couple hundred bucks. It is on the wall. It is not like you go to any other part of healthcare and you don't know what it is going to be. It is literally on the wall.

So we view MinuteClinic first as one way for redirection, redirecting people out of the emergency room. Again, when we do that, it is not just to MinuteClinic, it is to all alternative sites of care and to primary care doctors.

The second thing we're trying to do with MinuteClinics is help ameliorate the prime care shortage. As I said, 50 percent of people who come into MinuteClinic don't have a primary care doctor.

Q. Is that 5-0?

A. 5-0. Fifty percent.

We refer millions of people a year to primary care doctors.

Again, what we know is that when you get people into the healthcare system and become at least a semi-regular visitor to their primary care physician, they do better. Not that surprising.

So we're trying to close some of those gaps. And when you think about the access, it is not just that there may be a two- or three-month wait for a physician visit. The other issue for a lot of people is timing. Right? We're open nights, weekends. Again, about half of our visits are nights and weekends.

And I think -- and I haven't proven this yet -- but just in talking to a lot of our customers, that assurance, that transparency. You know, I can go on the website and see the wait time at the 7 MinuteClinics near me. One is 7 minutes, one is 15 minutes, one is 18 minutes. I know the visits are going to be between 20 and 30 minutes. And I know exactly what it is going to cost. So there is no uncertainty about what I'm getting myself into.

I think that really helps people. So that combination, I think, is why we're seeing such dramatic increases in visits in these clinics.

THE COURT: Those are people who do not have insurance coverage?

THE WITNESS: Many of them have insurance coverage. MinuteClinics are covered by most insurers, as well. So many people have insurance coverage but, again, are choosing to use it.

I think 10 years ago you would probably never of thought of going into a drug store for an immunization, a cough or a cold. We have seen 40 million people since then.

And the thing that I'm proudest about in MinuteClinic is they're a hundred percent guideline driven. If we can't get a good guideline and aren't confident that we can manage the nurse practitioners to that guideline, we will not provide the service.

And if you used antibiotic conservation, meaning not prescribing antibiotics when they're not needed, as a marker of guideline adherence -- and we have published this in peer-reviewed journals -- MinuteClinics outperform everyone, every institution, including the biggest name integrated delivery systems that you know of. And it is really because we pick what we're good at, we do that, we do it really well, and we do it a lot. And that's really the secret sauce of being good at anything in medicine, making sure that you're doing it a lot and you're doing it according to guidelines.

BY MR. PITT:

Q. We've also heard some concerns that CVS's PBM, CVS Caremark, might steer patients away from independent or specialty pharmacies and into CVS retail or mail order pharmacies.

Is that something that CVS Caremark would do, and if not, why not?

A. So a couple of things. So, first, our customers define what their network instruction is. If I went to a customer and said, you can only use CVS, they would say, well, if you're going to do that, you're going to give me an incredibly good price, and they might make that decision. That has not happened in the world. People don't want to disrupt their members and force them to go all over the place in retail pharmacy.

So generally, almost all -- I would say the average network is probably in the 50,000 or more, getting close to 60,000. That is number one.

Number two, we actually reimburse -- this came out in Ohio -- we reimbursed independents often at a higher rate than our own pharmacies. We need independents in the pharmacy, we need them to -- in the chain, in the network -- we need them to create the appropriate geo-access standards so that people are within a reasonable driving distance from a pharmacy.

With respect to specialty and mail order, what we have seen -- and this has been -- this has been for 20 years that I have been in the specialty business -- increasingly customers are choosing one pharmacy for all their specialty needs, and they're doing that for a few reasons. One is price. Two is administrative simplicity. I get one report from one entity. Three is quality. The largest PBMs -- the largest specialty pharmacies have demonstrated really outstanding service metrics, really outstanding quality metrics from an adherence perspective. So they haven't found a need for broader networks.

And the last is -- those are the big reasons.

THE COURT: Five minutes.

MR. PITT: I have nothing further unless Your Honor has further questions for the witness.

THE COURT: I don't think I do.

(Witness excused)

THE COURT: We will take a 10-minute recess and come back and hear the last witness of the day.

(Recess taken)

THE COURT: All right. Are you ready to call your next witness?

MR. PITT: Yes, Your Honor.

We call Terri Swanson.

THE COURT: Will the government do part of the examination or not?

MR. OWEN: Your Honor, the United States will listen closely to the testimony of Ms. Swanson and, if necessary, ask questions at the very end.

THE COURT: At the very end, okay.

TERRI SWANSON,

having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PITT:

Q. Good afternoon, Ms. Swanson. Could you state your full name for the record, please.

A. Terri Swanson.

Q. And what position do you hold with Aetna?

A. I'm Vice President of Medicare Product and the

Medicare Part D Business.

Q. How long have you been at Aetna?

A. I joined Aetna in 2010.

Q. And have your job responsibilities remained the same during your time at Aetna, or have they changed at all?

A. When I joined in 2010, I came as Vice President of Medicare Part D Business. In 2017, I added responsibilities for Medicare Product.

Q. And since the merger, have you taken on additional or different responsibilities?

A. The Part D Business for Legacy Aetna is the PDP being divested to WellCare. So in addition to my usual responsibilities, I'm also the executive responsible for that divestiture.

I also do -- work closely with new counterparts at CVS on the integration planning.

Q. Can you explain what the components are of Aetna's Medicare business?

A. Yes. Our Medicare business includes Medicare Advantage products, Medicare Part D products, and Medicare Supplement.

Q. What is the difference between Medicare Advantage and Medicare Part D?

A. Medicare Advantage includes medical benefit, both inpatient and outpatient. And it can also include integrated

prescription drug coverage. Medicare Part D, on the other hand, is standalone prescription drug coverage.

Q. Who are the subscribers to Part D plans, as a general matter?

A. Generally, Medicare beneficiaries. So our members are typically seniors on a fixed income, very value conscious, price conscious. The products are also sold both individually to just average people and they're sold through employer groups and other group-type customers, as well.

Q. Okay. How long have you been working in the Part D area?

A. I started working on Part D when the program originally was conceived. So Medicare Part D first went live on January 1st of 2006. I started working on it about a year in advance of that to build out the program at Cigna, my employer at the time.

Q. Could you describe for the Court your employment history prior to your time at Aetna.

A. Yes. I originally worked in the technology industry. I joined the PBM industry in about 1994. I worked for both Diversified Pharmaceutical Services and Express Scripts. I spent a couple of years at different start-up companies also in the healthcare and prescription supply chain space. And then I moved to Cigna, where I was CIO for their internal pharmacy benefit management division. After that, I spent

two years at Well Point Anthem, managing their Medicare Advantage and Medicare Supplement businesses. And then came to Aetna, where I still serve.

Q. What is your educational background?

A. I have a Bachelor's Degree from The University of Minnesota in Computer Science and a Master's Degree, also from The University of Minnesota, in Management of Technology.

Q. Now, I would like to talk a little bit about WellCare, the divestiture asset purchaser.

First, in the course of your work for Aetna, did you come to understand the characteristics of other companies that compete in the Medicare space?

A. Yes. We look closely at our competitors every year as we're preparing to renew our plan designs, our pricing, our filings. And WellCare is definitely one of the competitors that we have kept an eye on over the years.

Q. As one of the people who has been involved in managing the transition of Aetna's Part D assets to WellCare, have you had opportunities to observe and work with WellCare's management team?

A. I have.

Q. And have you formed any sort of view of what kind of management team they have?

A. Yes. They're a very capable and experienced

management team.

Q. Could you describe for the Court, first, the size and scale of WellCare kind of as an overall enterprise.

A. Yes. WellCare is a Fortune 200 company. They have around 18 billion in revenues, about 12,000 employees, and they serve 5 and a half million members in government programs, and that's excluding the divestiture from Aetna.

Q. So now talking about WellCare's Part D business in particular. Excluding the divestiture assets, how would you characterize the size and scale of WellCare's Part D business?

A. WellCare's Part D business, if you look, you know, prior to this most recent annual enrollment period, they had about 1.1 million members in their individual Part D plans. This fall, during annual enrollment, they added around half a million members. So they were about 1.6 million members prior to this acquisition of Aetna's business.

Q. When you said this past fall they added half a million members, that was without the divestiture assets having become part of WellCare; correct?

A. Yes. That's right.

The timing of doing the plan designs and filing your bids is in the beginning of the year. So they would have planned and filed those bids many months in advance of the divestiture becoming available to them. So it was all done,

really, on their own capabilities and understanding of the competitive space.

Q. So how did they achieve all of that growth?

A. They launched a low-cost or low-premium enhanced plan. By enhanced, in the Part D space, that means the plan has benefits that are greater than the Medicare standard defined benefit. So it is a very attractive plan at a very low premium. And that is definitely the kind of plan that our sort of cost-conscious Medicare beneficiaries gravitate towards.

Q. What, if anything, does that tell you about WellCare's capabilities in this area?

A. For me, it tells me that they're very capable of putting a competitive product into the market without any of the assets that they will now be acquiring from Aetna. It also certainly tells me, to put a low-premium enhanced plan like that into the market, that they do have a very cost-competitive structure. Again, you know, prior to this divestiture.

Q. Now, how does WellCare's recent growth compare to Aetna's?

A. Aetna had a plan very similar to the one that WellCare launched this year. Theirs was maybe a dollar or two less expensive than ours in terms of premium. And our growth was about 150,000 members compared to their 500,000.

So again, very similar. Very, very competitively positioned products. But our shopper values that dollar or two in premium per month.

Q. Now taking into account the merger and the divestiture, how does the merger change WellCare's size and scale in the Part D market?

A. By the end of this year, the Aetna business will be at about 2.5 million members. So added to WellCare's current business, they will be right around the 4 million member mark, so double in scale, more than double what they were prior to this acquisition.

Q. What, if anything, does that additional scale enable WellCare to do?

A. The additional scale certainly gives them additional leverage as they're negotiating with their PBMs or other suppliers that they will do business with. And it is just a very price-sensitive business. So having that scale gives them an ability to leverage their other assets across a larger membership base and contributes to a sustainably competitive cost structure, which is tremendously important in this space.

Q. I would like to give the Court a little bit of a sense of who participates in the Part D market and what the competitive conditions are like in that market.

Along those lines, could you first, based on your

experience, characterize the degree of price competition in the Part D market.

A. It is very price competitive. Like I said, our Medicare beneficiaries have demonstrated over and over again that they prefer a low-premium plan. In terms of the major competitors nationally, we have SilverScript --

Q. And SilverScript --

A. Is the CVS-owned PDP. UnitedHealthcare has a large PDP. Humana. Cigna. I'll skip over Aetna. WellCare. And EnvisionRx is owned by Rite Aid. That is also a national competitor. Then there are a variety of regional competitors depending on the footprint. For example, the Blues plans will serve people in their state or a portion of the state.

Q. Is ESI also a national competitor?

A. Yes, ESI is a national competitor, as well.

Q. How easy or difficult is it for consumers to compare the benefits and premiums of the various plans?

A. It is very straightforward. CMS has a tool called Medicare Plan Finder. That is available on the CMS website for everyone. All the plans have to provide their plan designs, their pricing. So you can tell on Plan Finder the price of a specific drug at a specific pharmacy for a specific plan. So it is very detailed.

There are 19 to 26 plans in every region. So every beneficiary has all of those plans to choose from. It is a

lot of plans. But they can see them compared on a literally apples-to-apples basis on that website. So it is very easy for them to compare the plans and see which one is going to be the best value for them depending on what drugs they take and what pharmacy they want to go to.

Q. How easy or difficult would it be for consumers to switch plans?

A. It is very easy for them to switch. If they're comfortable doing that online, there is a button that they can push that says, "Enroll me in this plan." The site also gives all the phone numbers for the plan, so if they're more comfortable talking to someone from the plan, asking questions before they enroll, they can call, and the plans will happily enroll them over the phone, as well.

Q. Who else, if anyone, do Part D plan sponsors compete with for members?

A. We also compete with all of the Medicare Advantage plans. So the individual Medicare Advantage plans, again, kind of bundle medical and the drug coverage, and some people like those. So they can also compare those on the CMS website.

Q. Getting back to WellCare now for a moment, what is your understanding of WellCare's experience in the Part D market?

A. WellCare has been a national competitor in the Part D

market since its inception. So they have been engaged since 2006. And they have a very experienced and -- I don't know -- sort of a lot of continuity in their management team. And the people who run the program today are some of the same people who started the program in 2006.

Q. Does WellCare specialize in government insurance programs?

A. They do.

Q. And can you help us understand how it is that government-sponsored insurance programs differ from commercial insurance programs?

A. Yeah. The government-sponsored plans like Medicare Part D, Medicare Advantage are very, very highly regulated by Medicare. So everything from the way we price the products, the benefit designs have to pass certain actuarial standards. There's a lot of technical data that is filed, meaning turned over to CMS, along with that pricing and that bid. Like I said, for Plan Finder, all of your data is turned over to CMS and made available transparently to members. The way that you process the plan is also regulated, so you have to answer the phones in a certain amount of time. Your claim processing is subject to certain rules. You send copies of all your claims to CMS, and they can review and audit that. So it is really -- every aspect of the business is visible to CMS, heavily regulated, heavily audited.

Q. Now, the flip side of that as to WellCare is that WellCare has no commercial business; correct?

A. That's right.

Q. And based on your experience, has WellCare's lack of a commercial insurance business harmed its competitiveness in the Part D space?

A. It really hasn't. Typically, contracts for Medicare business are negotiated separately from the commercial contracts, and you really are not allowed to subsidize across those businesses. The regulations and the filings just make all of that very visible to CMS. So if you look at their results in terms of this most recent period, I think it is quite evident that they were the most competitive, the most successful growing PDP this year, and they don't have a commercial arm. So they were very capable of executing on that without the other line of business.

Q. We heard some testimony yesterday suggesting that WellCare might not be a strong enough divestiture buyer, and some of the reasons that we heard -- I will kind of read off and then first ask you as a general matter if you agree with that, and then we can discuss each of them. I believe what we heard was first that WellCare has a weaker brand than Aetna. Second, that it hasn't been able to grow its market share as much as Aetna in recent year. And then third, that WellCare is smaller than Aetna when you take into account

that Aetna has a really big commercial business, as well.

So, first of all, as an overall point, do you agree with those criticisms of WellCare as a divestiture buyer?

A. Not really. I mean I think the facts of our most recent experience just would indicate otherwise. So if you start with the brand, go back to the brand and growth, the Plan Finder experience that I talked about, it definitely shows you what the brand is. So you can see the name of the plan and know what you're comparing.

But again, our beneficiaries are shopping based on value and what is going to deliver the most value for them. And if we look at -- if we look at this most recent period, Aetna's plans under the Aetna brand were a dollar or two more expensive. We had far less growth than WellCare did with very similarly situated plans. So the brand was not able to overcome that price difference. They have been able to grow. And then I think we just spoke about the commercial. The commercial business really is a separate line and has not negatively impacted their ability to be competitive in Part D.

Q. Just to be clear, that growth that you're describing that WellCare had, that was under the WellCare brand, not any other brand; correct?

A. Yes, that was a WellCare plan, correct.

Q. As the head of Aetna's Part D business, have you had

occasion to compare Aetna's premiums against its competitors' premiums in that space?

A. Yes.

Q. And how do WellCare's premiums compare with Aetna's kind of over time?

A. Well, again, in the most recent period, their premium was a little bit lower than ours on this enhanced plan, which is really the type of plan that members are most typically shopping for. Other plans, over time, you know, the premiums kind of move around a bit from year to year, but I would say very comparable in terms of the premium placement.

Q. We have talked a lot about PBMs. I would like to ask you just a couple of questions.

First, does Aetna have its own PBM?

A. We do not. We have an arrangement with CVS Caremark or the CVS PBM that has been in place since 2010.

Q. And prior to the merger, did Aetna have any plans to offer standalone PBM services to customers?

A. We did not.

Q. Does WellCare own a PBM?

A. They do. They acquired a PBM.

Q. Now, after the merger, does WellCare have to rely on CVS Caremark for PBM services?

A. WellCare does use CVS Caremark for PBM services in their Part D business today. They can choose to continue to

do that, or they could potentially go another direction. I know we talked -- or others talked earlier -- about their announcement of going out to bid and looking at what the market may bring to them in terms of other competition. So they've got different options.

Q. So if CVS Caremark tried to raise WellCare's prices for PBM services, does WellCare have other options that it could turn to to try to undercut those prices?

A. Yeah, absolutely. I mean the PBM market is also a very, very competitive market. And I think both the other large PBMs in the space as well as some of the other maybe medium size PBMs would be very, very interested in having the opportunity to compete for that WellCare business.

Q. Why is that?

A. It's a large attractive book of business. So it adds to their scale. The PBM business is also a scale business. And as some of these accounts change over, one PBM may have excess capacity. If they have lost a client to somebody else, they may be working very hard to fill it. So it is a very competitive bidding kind of situation.

Q. I would like to now discuss the divestiture remedy in this case.

A. Uh-huh.

Q. First, have you been involved with the divestiture process?

A. Yes. As the business owner for the Legacy Aetna PDP, I was involved as a subject matter expert in developing and discussing what services to provide in the transition agreement. I'm also the executive responsible for executing the divestiture and making sure that it goes smoothly.

Q. Now, are you aware that the government found potential anticompetitive harm in 16 of the 34 CMS regions?

A. Yes.

Q. Okay. But are you also aware that Aetna has agreed to a total divestiture of its Part D assets in all regions?

A. Yes, we have.

Q. And how does that affect WellCare's ability to compete?

A. Well, for WellCare, it is a nice -- it is a nice opportunity. It gives them additional scale in every region rather than just in the 16 or so that were found to be competitively sensitive.

Q. Now, in addition to selling Aetna's whole Part D business to WellCare, are CVS and Aetna also providing transition services?

A. Yes, we are.

Q. So, first, how is it that it has been decided which services get provided to WellCare and what the timeline for the transition is? So, both, who has been making those decisions and what are the decisions?

A. Sure. We, being Aetna and CVS, as part of the negotiation worked with WellCare to establish both a timeline and a set of services that would be necessary and desirable to make a very smooth transition. And the timing of that is really based on the business cycle for Medicare Part D.

So every year in the beginning of the year you do your bid. You start your work maybe the previous year or early in January. And that bid is filed the first Monday in June of each year. Then you have preparing for open enrollment. So open enrollment happens in the fall. You take the summertime to prepare for it. And marketing starts on October 1st. Then people enroll. And then on January 1st of the next year, they come up kind of live in those new plans that were filed in the first half of the year.

So when we looked at that natural business cycle, we laid out a transition plan that said, okay, Aetna will continue to run kind of all the core services, all the claims processing and picking up the phones and servicing members, doing everything that we have done for these members because they had just elected the plans last fall, they had just bought these plans. So we are continuing to provide sort of the normal services.

In terms of the bid for 2020, because that is now WellCare's business, they performed that activity. Aetna was not engaged in it because we and CVS are a competitor, so

they did their bid.

Now, in the fall, they will enroll people into those new plans that they bid. And effective the first of the year people will get their new ID cards, they will be a WellCare member.

For the members, it is a very, very natural kind of point in time to transition. So they will see that they're moving from an Aetna plan to a WellCare plan. It is not disruptive to them in the middle of the year. There aren't unexpected changes. So it was really designed to make it very smooth and respectful of the member.

The other thing about the transition is, because it is Medicare business, it is of course regulated, and CMS also reviewed and approved this plan.

Q. So did CVS approve the timing of the transition and of the transition services that are being provided?

A. Yeah. I mean CMS approved the way -- CMS doesn't really get involved in who does what services, right? But what CMS gets involved in: Are you doing the right thing for these beneficiaries? Are you treating them right? Are you disrupting them?

CMS approved sort of the timeline of the plan and when we would communicate with them about the different changes.

Q. So to the extent that somebody might suggest that

only providing those transition services through the end of calendar year 2019 is not sufficient in order to enable WellCare to be a good and strong asset purchaser, how would you respond to that?

A. Yeah, I would say that it doesn't align kind of with the business cycle. So when you look at the business cycle, it is a calendar year plan, it makes sense to run the calendar year plan the way it has been running smoothly, not to do some kind of mid-year transition that would be potentially disruptive at a time when people are not expecting a change. But at the same time, going beyond that, there will be run-out services because sometimes a pharmacy might send us a claim in January for a service that was performed in December. We will have the ability to continue to support WellCare and support those members for a run-out. But for the newly -- kind of newly defined plans for WellCare's opportunity to market their plans and serve what are now their members, January 1st is really the ideal time to make that transition.

Q. We also heard some concern yesterday that perhaps WellCare might not be able to handle such a massive increase in insured lives. Could you speak to that?

A. Sure. It certainly is a large block of business. And part of the good news is that they do have an existing sort of large-scale business themselves. So they're

accustomed to supporting this order of magnitude of lives. They will have to scale certain operations. Most of those are core services that are offered through the PBM. In working with their PBM partner, in this case CVS's PBM, they should be able to scale to support that business. They have been supporting it on behalf of Aetna, so they should be able to support it on behalf of WellCare, as well.

Q. So on the topic of PBM's, we heard testimony yesterday to the effect that a PBM is like the engine of a car and is responsible for things like benefit design and that it could narrow its pharmacy network as a point of leverage. So can you speak to the accuracy of that characterization.

A. Sure. I mean -- I think the engine is a great analogy for a lot of the -- kind of the high-volume transaction processing that the PBM provides in support of health plans. But the engine of the car, it is part of the car, the engine doesn't design the car. I think of the health plan as designing the car. We, as Aetna in this case, decide what our plan design is going to be. We decide what type of premium we want to charge. We decide what type of benefits we want to offer. We do consult with the PBM and work with them to determine how best to deliver that. But in terms of the decision-making, we are the contract holder with CMS. We file the plans. We take input from the PBM. But

mostly the PBM takes direction from us and executes on that direction to deliver the service and deliver the plan to our members.

THE COURT: Direction in what sense?

THE WITNESS: Well, direction in terms of what the plan is. So we communicate to them and say, okay, the premium is $15, the tier 1 cost share is zero, the tier 2 cost share is $5. Kind of all of those different plan parameters.

We would also would give them direction on policies. So we might say, for a particular drug, we're going to require prior authorization on that drug because we want to have validation from the doctor that it is medically necessary.

THE COURT: So what is it that they're doing to compete with one another to try to get your contract?

What is it that they are offering you in competition with others -- and I might add, unknown competition since they don't see the other bids -- what is it that they are offering you that they can provide you to hopefully meet your goals and parameters?

THE WITNESS: So they do have to be -- since our customer is very price sensitive, we have to be very price sensitive. So one thing is price. And we do evaluate them both on the cost to deliver their services, as well as the

value that they can help us derive both from the pharmacy network and the formulary, as others have talked about.

We also, as a Medicare plan, we are very, very, very focused on compliance and on their ability to truly execute against all of the technical requirements that Medicare places on us because we have to hold them accountable.

THE COURT: Compliance with what? Paperwork?

THE WITNESS: Well, the regulations are typically not executed in paperwork because it is a very high-speed, technical online processing environment. But, for example, in claims processing, there are all kinds of different Medicare rules that apply to processing a claim. So if the claim is in a deductible phase, it has to process a certain way. If it is for a low-income member -- there are different levels of low-income. The PBM has to be able to differentiate different cost sharing for those different levels of subsidy.

THE COURT: Some PBMs are better at processing these kinds of things?

THE WITNESS: Some PBMs are better at processing than others. Some have a better track record at compliance than others. It is a very key consideration for us as a Medicare plan because that is how CMS judges are.

THE COURT: How about network of available pharmacies?

THE WITNESS: Network of available pharmacies is very important, yes.

THE COURT: They submit to you prices, price structure, network of available pharmacies, and they submit to you their track record of compliance?

THE WITNESS: Yep. Or we perform due diligence, go and do site visits, kind of kick the tires, so to speak, on their operations and make sure that we see that they can do what they might be presenting to us they can do.

THE COURT: You don't give them guidance on how to conduct negotiations with the wholesalers and manufacturers, do you?

THE WITNESS: We don't give them guidance on how to perform their negotiations. But we do, as a large health plan, we definitely customize our formularies, and we customize our network. So we might say to them, for example, if you want us to put drug X on the formulary on a certain tier, we need you to get it to price point of Y. If you can get it there, great, we'll act on that. If we can't get it there, if you can't get it there, then we're going to go a different direction.

So we will give them sort of expectations of what we need in conjunction with everything else that we're packaging into our plan, is going to give us the competitive position that we think we need when we file our bid.

THE COURT: Do you have any influence over the PBM bidder as to what fee that company will be able to charge?

THE WITNESS: Well, we want the fee to be as low as we can get it. So we definitely would negotiate those as part of a contract negotiation. Absolutely. Absolutely.

THE COURT: But you can't dictate that, you have to negotiate it?

THE WITNESS: We can't dictate that. We would negotiate it. That's right.

THE COURT: Thank you.

BY MR. PITT:

Q. How do you know whether you're getting a good deal from a PBM?

A. We do have the ability to go out to the market and look at other price points.

THE COURT: When you do that -- I've heard it is a black box -- how do you get that confidential information?

THE WITNESS: Well, you know, if they want to bid on the business, they have to provide information.

THE COURT: They do market checks; right?

THE WITNESS: Yes.

THE COURT: Every few years.

THE WITNESS: Yes. Yes.

THE COURT: They participate in that?

THE WITNESS: Yeah. And the market check is very

much -- it is kind of the same thing as going out to bid. It is the same process. You're asking for pricing, and you're evaluating what services you're going to get for the pricing that they're willing to offer you. So, yeah, the market check is a good mechanism.

We also have access to things like --

THE COURT: How about rebates; do you have any control over what rebates they're going to get from the manufacturers and the wholesalers?

THE WITNESS: I don't know if I would say control.

THE COURT: Input.

THE WITNESS: We have expectations. Absolutely. We have expectations and input.

THE COURT: What does that mean, expectations?

THE WITNESS: Well, we would say, for example, if I note that I got a rebate level of X in 2018, I would have an expectation that they should be able to improve on that for 2019. So I have a history, as do all plans. But we know what we've been able to achieve and what our PBM partners have been able to achieve year over year.

We also know what is coming in the drug pipeline, what might be going generic or what new brands might be launching. That is always going to have an influence up or down on what you can expect. So we model what we think is reasonable and appropriate, and we probably push harder on

that than -- you know, because we want to get the best that we can possibly get. But we absolutely do our own analysis and modeling so we can form our own opinions about what's competitive and what's expected for us to stay competitive versus just sort of take what they give us.

THE COURT: Okay.

BY MR. PITT:

Q. And do you also make use of consultants, or can you make use of consultants in that process?

A. We can. Many of our customers routinely use consultants, particularly the employer groups and other health plans. We may or may not use consultants in a market check because we just have a lot of experience and we have a lot of our own analysis within our walls. So we may or may not choose to take advantage of those resources depending on the situation.

Q. Now, we have discussed, I think, that WellCare uses CVS Caremark for its PBM services. But WellCare also competes with SilverScript, which is CVS's PDP plan; right?

A. That's right.

Q. And how, if at all, has that dynamic affected the competitiveness of WellCare's individual PDP business in the past?

A. You know, it hasn't. Both Aetna pre-acquisition competed with SilverScript, as does WellCare, as do the other

health plan clients that CVS PBM supports. And, you know, we do have an -- we all have seen our results. So I think Aetna has been very competitive. WellCare has been very competitive. And we have been successful in having a competitive cost structure using CVS as a PBM, a variety of us have. So it's really not been a negative from my point of view.

Q. How does CVS prevent its ownership of SilverScript from affecting CVS Caremark's relationships with other Part D customers?

A. Yeah, the PBM is very careful in how they apply firewalls to make sure that the client, whether it is Aetna or WellCare or another client, that that client's data and competitively sensitive information is not shared with anyone else. It is not shared with other clients, and it is not shared with other people within the PBM who service those other clients. So it is very limited number of people who can have access to a given client's competitively sensitive information.

THE COURT: Who polices that? Who is it within the company of the PBM that makes sure, kind of like an IG, who makes sure that the firewalls aren't being breached or that they aren't in some way being taken advantage of?

THE WITNESS: The firewall policies are corporate policies. So corporate legal has kind of vetted those with

the different businesses. Employees who work in the segments that have firewalls that have to be managed are educated on those every year. So there's annual training that people go through. And there's also technical -- there is sort of -- it's not just the honor system, there's also technical barriers. From an IT standpoint, a client's data would be isolated in a specific database, and only certain people who are approved to have access to that data have permission to access that data, and those access controls are reviewed on a regular basis, as well.

THE COURT: The negotiation team is limited to certain people who have access, and others can't have access to it?

THE WITNESS: That's right. That's right.

BY MR. PITT:

Q. Is it also in CVS's financial interest to ensure that its firewalls remain unpenetrated?

A. Yeah, absolutely. As a PBM, the PBM can only be successful if they're able to serve multiple different clients who do need those same services and who compete with one another. If the PBM is unable to give their clients assurance that their data is going to be kind of sacrosanct, if they can't do that, they're not going to be successful in this business.

MR. PITT: I have no further questions unless Your

Honor has further questions for the witness.

THE COURT: Mr. Owen, do you have any questions for the witness?

MR. OWEN: No questions from the United States, Your Honor.

THE COURT: Very good. You're excused.

THE WITNESS: Thank you.

THE COURT: Thank you.

(Witness excused)

THE COURT: All right. Counsel, I will give the very able reporters who have been covering these hearings a week or two to get their transcripts in final form, and you all will have access to them, obviously. And then I will give you a period of time -- I haven't figured out the exact schedule yet -- but I will give you a period of time to supplement your briefs with anything that came out of these hearings that you think would be advantageous, helpful to your arguments that you have already made either in favor of the entry of Final Judgment or in opposition to the entry of Final Judgment. And then I will set a day for oral arguments and a schedule for oral arguments. I will hear arguments from all three parts of the puzzle here, although I think my guess is that the CVS Aetna, they have the same interests, so it will probably be just them and the Department of Justice. So two here and one here. On the amicus side, they will have

to give some thought about having one party speak for the others since they have common interests, too, but we'll think about that.

I'm thinking that the oral arguments will probably be in July. It is going to take at least a week-plus, maybe a week and a half to finalize these transcripts, and then give you all a week and a half to two weeks to do whatever supplemental briefing you want to do, and then probably set the oral arguments sometime in the second or third week of July. I haven't figured that out yet. I have to look at my own schedule. So be on the lookout for an order to that effect.

As much as I would like to negotiate the busy schedule of all the lawyers in this room, I can't. So I will pick a date that I think will work for as many of you as possible, but I will not be in a position to negotiate the actual day and time. We're going to need a few hours of time for the arguments. So I will probably be blocking off an afternoon of a particular day sometime in July.

For those of you who have made arrangements to be in Nantucket or Martha's Vineyard, you might want to re-evaluate that.

MR. OWEN: Your Honor, I have an additional matter, if I may.

THE COURT: You always have another matter, Mr. Owen.

It better be important.

MR. OWEN: Yes, it is important, Your Honor.

THE COURT: What does it relate to?

MR. OWEN: Your Honor, it relates to the fact that there have been multiple inaccuracies that remain on the record here, and the United States would like to request an opportunity to potentially call additional witnesses and present its full rebuttal case.

THE COURT: Mr. Owen, put it in the form of a motion, lay it out jot and tittle.

It will give you something to do, okay?

And then we will see what the opposing parties have to say, if anything, if they want to oppose it.

But the Court is not inclined at the moment anyway to open this back up. This was done for the purpose, as I expressed to you on a number of occasions, to assist the Court in evaluating this case. This is not a trial, Mr. Owen. You seem to have difficulty in understanding the distinction.

We stand in recess.

(Proceedings adjourned at 5:03 p.m.)

CERTIFICATE OF OFFICIAL COURT REPORTER

I, Patricia A. Kaneshiro-Miller, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ Patricia A. Kaneshiro-Miller — June 6, 2019

PATRICIA A. KANESHIRO-MILLER — DATE

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